New Jersey Department of Health and Senior Services
Vaccine Preventable Disease Program
PO Box 369
Trenton, NJ 08625-0369

VACCINES FOR CHILDREN PROGRAM
PROVIDER PROFILE

All public and private health care providers approved by the State for participation in the Vaccines for Children Program (VFC) must complete this form. This document provides shipping information and helps the State determine the amount of vaccine to be supplied through the NJ VFC Program. The form also may be used to compare projected vaccine needs with actual vaccine supply. The New Jersey Immunization Program will keep this record on file with the "Provider Enrollment" form. The Provider Profile form must be updated annually or more frequently if: (1) estimates of children served changes, or (2) the status of the facility changes. The form is to be completed for each provider site location and this form may be completed by one provider for the entire practice.

A. Employer Identification Number (EIN)	Provider ID Number (PIN):

B. Name of Facility or Provider Name (Last, First, MI)

C. Name of Contact Person (Last, First, MI)

D. Vaccine Delivery Address **(NO PO BOXES)**

Street Address: _____

City, State, Zip: _____ County: _____

Office Hours (Days/Hours)

Telephone Number	Fax Number	Email Address
( )	( )	

E. Names of Other Physicians at the provider site who will also administer vaccines as VFC Program participants **(Please fill out IMM-26A form attached.):**

F. Type of Facility (Check Only One):

- 10 ☐ Public Health Department
- 12 ☐ Public Hospital
- 16 ☐ Other Public
- 20 ☐ Private Practice (Individual or Group)
- 22 ☐ Private Hospital
- 24 ☐ Other Private
- 25 ☐ Federally Qualified Health Center (FQHC)
- 32 ☐ Other Immunization Projects

NOTE: The following information must be based on data and not estimates. Please document the data source for this information in the boxes provided in Section I.

	<1 Year Old	1-6 Years	7-18 Years	Total
G. For the 12-month period beginning 1/1/2004, project the total number of children who will receive vaccinations at your practice/clinic:				
H. Of the total numbers entered in Section G, estimate how many children are expected to be VFC eligible because they are: **(Note: Do not count a child twice or in more than one of the categories listed below):**				
Enrolled in Medicaid and NJ FamilyCare/ KidCare (Plan A)				
Enrolled in NJ FamilyCare/KidCare (Plans B, C, D)				
Without any health insurance				
American Indian or Alaskan Native				
Underinsured *(Complete only if F-10 or F-25 above is checked)*				
TOTAL				

I. **Type of data used to determine projected children served in Section G and Section H:**

- A ☐ Doses Administered Data
- B ☐ Medicaid Claims Data
- C ☐ Provider Encounter Data
- D ☐ Registry Data
- E ☐ Other (Specify): _____

Signature	Date

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